TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Baylor Scott and White Surgical Hospital

Respondent Name
Norguard Insurance CO

MFDR Tracking Number
M4-17-1615-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 27, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This claim involved implants. We are requesting separate payment of the cost of implants plus 10% as indicated in these guidelines."

Amount in Dispute: $37,742.05

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our initial response to the above referenced medical fee dispute resolution is as follows: we have escalated the bill in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 07, 2016 to March 08, 2016	Inpatient Hospital Services	$37,742.05	$9,987.84

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.404 sets out the acute care hospital fee guideline for inpatient services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 00084 – (16)Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

- 00134 – (94)Processed in excess of charges
- 00137 – (97) The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
- 00201 – (B12) Services not documented n patient's medical records
- 00223 – (P12) Workers' Compensation Jurisdictional fee schedule adjustment
- W3 – Request for reconsideration

Issues

1. What is the applicable rule for determining reimbursement of the disputed services?
2. What is the recommended payment for the services in dispute?
3. What is the additional recommended payment for the implantable items in dispute?
4. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute relates to facility medical services provided in an inpatient acute care hospital. No documentation was found to support that the services are subject to a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011. The division established above that the requestor is eligible for reimbursement subject to the provisions of 28 TAC §134.404 titled *Hospital Facility Fee Guideline – Inpatient*. Reimbursement is calculated pursuant to 28 TAC §134.404 (f), which states, in pertinent part:

   > The reimbursement calculation used for establishing the MAR [maximum allowable reimbursement] shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   >
   > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   >
   > (A) 143 percent; unless
   >
   > (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent.

   Review of the submitted documentation finds that separate reimbursement for implantables was requested; for that reason, the MAR is calculated according to §134.404(f)(1)(B).

2. Per §134.404(f)(1)(B), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment by 108%. Information regarding the calculation of Medicare IPPS payment rates may be found at http://www.cms.gov.

   Review of the submitted documentation finds that the DRG code assigned to the services in dispute is March 07, 2016 to March 08, 2016. The services were provided at Baylor Scott White Surgical Hospital. Based on the submitted DRG code, the service location, and bill-specific information, the Medicare facility specific amount taken from the *Medicare Inpatient PPS Pricer* is $22,324.80. A "VBP" claim payment in the amount of $371.10 is then **subtracted** from $22,324.80, resulting in a facility specific amount of $21,953.70.

   "VBP" stands for Value-Based Purchasing (VBP) payment. Medicare's VBP program was implemented to monitor and improve quality of care provided at inpatient hospitals participating in the Medicare system. The Medicare VBP conflicts with existing Texas Labor Code (TLC) sections 413.0511 and 413.0512 which provide for the review and monitoring of the quality of health care provided in the Texas workers' compensation system.

   Pursuant to 28 TAC §134.404 (d)(1) Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by the CMS in administering the Medicare

program. For that reason, the VBP amount does not apply and was therefore subtracted from the total indicated on the *Medicare Inpatient PPS Pricer.*

The total facility amount of $23,710.00, multiplied by 108% results in a facility-specific reimbursement amount of $27,108.61.

3. Additionally, the provider requested separate reimbursement of implantables. Per §134.404(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:

   "Cage Lumbar 22 28MM 11 MM" as identified in the itemized statement and labeled on the invoice as "No invoice supported" with a cost per unit of $0.00; "Cage Lumbar 22 28MM 11MM" as identified in the itemized statement and labeled on the invoice as "No invoice supported" with a cost per unit of $0.00; "Agent Hemostatic 4IN X 8" as identified in the itemized statement and labeled on the invoice as "Hemostat 4 x 8 Surgicel" with a cost per unit of $767.05; "Floseal Hemostatic Marti" as identified in the itemized statement and labeled on the invoice as "Floseal CHSD 10ML" with a cost per unit of $1,488.66; "Gelfoam sz 100" as identified in the itemized statement and labeled on the invoice as "No invoice supported" with a cost per unit of $0.00; "Sealer Bipolar Aquamanty" as identified in the itemized statement and labeled on the invoice as "Bipo sealer 23-312-1 AQM SBS 5.0 nuero" with a cost per unit of $580.00; "Applier Clip 11IN Med Mu" as identified in the itemized statement and labeled on the invoice as "Ligaclip MCA Med" with a cost per unit of $253.94; "BIO 4 Biable Bone Matrix" as identified in the itemized statement and labeled on the invoice as "No invoice supported" with a cost per unit of $0.00.

   Per §134.404(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.404(g). The facility's total billed charges for the separately reimbursed implantable items are $31,747.07. Accordingly, the facility's total billed charges shall be reduced by this amount when calculating outlier payments.

   The total net invoice amount (exclusive of rebates and discounts) is $3,089.65. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $308.97. The total recommended reimbursement amount for the implantable items is $3,398.62.

4. The total allowable reimbursement for the services in dispute is $27,108.61. This amount less the amount previously paid by the insurance carrier of $17,120.77 leaves an amount due to the requestor of $9,987.84. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $9,987.84.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $9,987.84 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		3/3/2017
Signature	Medical Fee Dispute Resolution Officer	Date
		3/3/2017
Signature	Medical Fee Dispute Resolution Director	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.